SERFF Tracking Number:	*GARD-126966349*	*State:*	*Arkansas*
Filing Company:	*The Guardian Life Insurance Company of America*	*State Tracking Number:*	*47678*
Company Tracking Number:	*DI-2011*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.007 Long Term - Related to marketing with employer or association groups*
Product Name:	*DI-2011*		
Project Name/Number:	*/*		

Filing at a Glance

Company: The Guardian Life Insurance Company of America

Product Name: DI-2011	SERFF Tr Num: GARD-126966349	State: Arkansas
TOI: H11I Individual Health - Disability Income	SERFF Status: Closed-Approved-Closed	State Tr Num: 47678
Sub-TOI: H11I.007 Long Term - Related to marketing with employer or association groups	Co Tr Num: DI-2011	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Cindy Ego	Disposition Date: 01/12/2011
	Date Submitted: 01/11/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 01/12/2011
	State Status Changed: 01/12/2011
Deemer Date:	Created By: Cindy Ego
Submitted By: Cindy Ego	Corresponding Filing Tracking Number:

Filing Description:

The Guardian Life Insurance Company of America is submitting applications DI-2011, Application for Insurance, and DI-NM-2011, Representations of Health Information, for your review and approval. They replace DI-2009 and DI-NM-2009 which were approved in your state on 09/17/2009, File # GARD-126259672. The submitted forms are filed in our state of domicile, New York, concurrently. If the forms submitted in your state contain a state suffix, all references in this letter to such form number without a state suffix apply to the suffixed version submitted.

The submitted applications, DI-2011 and DI-NM-2011, will be used to apply for individual disability income insurance by

both The Guardian Life Insurance Company of America (Guardian) and Berkshire Life Insurance Company of America (Berkshire Life). Berkshire Life is a wholly owned subsidiary of Guardian. A separate filing will be submitted on behalf of Berkshire. We would appreciate any efforts you can make to coordinate the review of these forms for the two companies. The Producer's Certification, form DI-PC-2011, is not considered part of the application, however, we are including this form for your Department's information.

Policy Numbers with which these applications will be used
AH55A 7/99 Business Reducing Term Disability Income Policy (Guardian)
NC56-A 7/99 Personal Reducing Term Disability Income Policy (Guardian)
4200 (01/10) Overhead Expense Disability Income Policy (Berkshire Life)
3200 (01/10) Disability Buy-Out Insurance Policy
1200 (09/04) Disability Income Policy (Berkshire Life)
1400 (06/10) Disability Income Policy (Berkshire Life)
1500 (06/10) Disability Income Policy (Berkshire Life)
1600 (06/10) Disability Income Policy (Berkshire Life)

The following forms that were approved in your state for both Berkshire Life and Guardian on 05/22/2003 will be used in conjunction with application DI-2011:

Form Number Description
C-ADU-SUPP-2003 Alcohol and Drug Usage Supplement
C-AVIA-SUPP-2003 Aviation Supplement
C-AVOC-SUPP-2003 Avocations Supplement
C-AP-SUPP-2003 Supplement to Application for Insurance
C-UNDINQ-2003 Underwriting Inquiry Form
C-NIIP-2003 Insurance Information Practices
C-AUTH-2003 Authorization to Obtain and Release Information
C-MED-2003 Representations to the Medical Examiner (Part 2)

Form DI-CR-2007, Conditional Receipt for Disability which was approved on 08/29/2007 will be used in conjunction with the submitted application.

We will also use Special Exceptions Agreement, form 71-SE (06/01) and Amendment to the Application, form 71-A (06/01), which were approved on 03/26/2001with DI-2011 and the Declaration of Insurability, form 2986-6-2001 which was approved on08/16/2001.

SERFF Tracking Number:	*GARD-126966349*	*State:*	*Arkansas*
Filing Company:	*The Guardian Life Insurance Company of America*	*State Tracking Number:*	*47678*
Company Tracking Number:	*DI-2011*		
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Product Name:	*DI-2011*		
Project Name/Number:	*/*		

In addition to using this application in the traditional paper situation, we also plan to use this application to take applications electronically using a computer. Please note that we are not referring to direct solicitation through the internet or other means. The sale of individual disability income insurance using this application will always involve a licensed agent. When the application is completed in this manner the application and all required forms will be printed at the end of the process and signed by the applicant. Additionally, the company may offer applicants completing their applications electronically the ability to sign the application using an electronic signature.

We also plan to make available an electronic signature option to insureds applying to increase their coverage by exercising a future increase option using the FIO-2009 application previously approved by your department on 09/30/2009. Under the electronic application procedure described above, the completed application at the end of the process will be an exact copy of the application forms as approved by your Department. In all circumstances, the applicant will be offered the opportunity to complete the application using a traditional paper application, with a pen signature.

Marketing

Our policies are marketed in an individual basis through our agency distribution system. Our products are mainly marketed to professionals such as physicians, attorneys and small business owners. Our policies are underwritten on an individual basis using information supplied or authorized by the applicant.

Company and Contact

Filing Contact Information

Cindy Ego, Compliance Specialist
700 South Street
Pittsfield, MA 01201
413-395-4319 [Phone]

Filing Company Information

The Guardian Life Insurance Company of America
7 Hanover Square
New York, NY 10004
(212) 598-8704 ext. [Phone]

CoCode: 64246
Group Code: 429
Group Name:
FEIN Number: 13-5123390

State of Domicile: New York
Company Type: Life
State ID Number:

SERFF Tracking Number:	*GARD-126966349*	*State:*	*Arkansas*
Filing Company:	*The Guardian Life Insurance Company of America*	*State Tracking Number:*	*47678*
Company Tracking Number:	*DI-2011*		
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Product Name:	*DI-2011*		
Project Name/Number:	*/*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	2 forms @ $50
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Guardian Life Insurance Company of America	$100.00	01/11/2011	43645795

SERFF Tracking Number:	*GARD-126966349*	*State:*	*Arkansas*
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Product Name:	*DI-2011*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/12/2011	01/12/2011

SERFF Tracking Number:	*GARD-126966349*	*State:*	*Arkansas*
Filing Company:	*The Guardian Life Insurance Company of America*	*State Tracking Number:*	*47678*
Company Tracking Number:	*DI-2011*		
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Product Name:	*DI-2011*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 01/12/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*GARD-126966349*	*State:*	*Arkansas*
Filing Company:	*The Guardian Life Insurance Company of America*	*State Tracking Number:*	*47678*
Company Tracking Number:	*DI-2011*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.007 Long Term - Related to marketing with employer or association groups*
Product Name:	*DI-2011*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Application for Disability Insurance	Approved-Closed	Yes
Form	Representations of Health Information	Approved-Closed	Yes

SERFF Tracking Number:	*GARD-126966349*	*State:*	*Arkansas*
Filing Company:	*The Guardian Life Insurance Company of America*	*State Tracking Number:*	*47678*
Company Tracking Number:	*DI-2011*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.007 Long Term - Related to marketing with employer or association groups*
Product Name:	*DI-2011*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: DI-2011

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/12/2011	DI-2011	Application/ Enrollment	Application for Disability Insurance Form	Initial		50.600	DI-2011 app package.pdf
Approved-Closed 01/12/2011	DI-NM-2011	Application/ Enrollment	Representations of Health Information Form	Initial		53.500	DI-NM-2011.pdf

GUARDIAN®

☐ **Berkshire Life Insurance Company of America**
Home Office: 700 South Street, Pittsfield, MA 01201
Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of The Guardian Life Insurance Company of America, New York, NY

☐ **The Guardian Life Insurance Company of America**
Administrative Office: 700 South Street, Pittsfield, MA 01201

(Please check appropriate company(ies). Any insurer checked above is herein referred to as the "Company.")

Application for Disability Insurance

I. Proposed Insured Information

a. Name (First, Middle Initial, Last) Suffix Previous Last Name, if applicable

b. Gender: ☐ Male ☐ Female

c. Social Security #: _____

d. Residence Address (Street, City, State, Zip):

_____

_____

How long at this address? _____

e. Date of Birth (mm/dd/yyyy): _____

f. Place of Birth: _____

g. Telephone: Home _____

Cell _____

E-mail Address: _____

h. Are you a U.S. citizen ☐ Yes ☐ No

If no, please provide: Visa Type _____ Visa Duration _____

How long have you lived in the U.S. on a full-time basis? _____
(If residence has not been continuous, give dates, and explain in Remarks and Special Requests section 10)

Do you expect to remain in the U.S. permanently? ☐ Yes ☐ No
If no, include details: _____

When do you expect to obtain U.S. citizenship or permanent residency? _____

2. Business Information

a. Current Employer: _____

Number of years with current employer _____

b. Business Address (Street, City, State, Zip):

_____

_____

c. Business Telephone: _____

Business Website: _____

d. Nature of Business:

_____

e. Occupation: _____

Number of years in this occupation _____

f. Job Title (if medical or dental occupation, state specialty):

_____

g. Professional licenses and designations held (if none, so state):

3. Occupational Information

a. Describe all activities performed in connection with the duties of your occupation, including but not limited to invasive surgical, travel, sales and supervisory duties. If the space provided is not adequate, provide additional details in Remarks & Special Requests section 10.

Description of Specific Duties	% of Time Devoted to Each Duty

b. Describe exact physical duties of your occupation (lifting, climbing, driving, etc.). If none, so state.

_____

c. Describe any tools or equipment you use to perform the duties of your occupation. If none, so state.

_____

d. Is this a home-based occupation? ☐ Yes ☐ No If yes, what percentage of time do you spend working outside the home? _____%

e. How many hours per week are you at work in this occupation? _____ hours

f. Have you been continuously at work full time performing the usual duties of your occupation for the past six months? ☐ Yes ☐ No
If no, explain in section 10 Remarks and Special Requests.

g. Do you supervise any employees? ☐ Yes ☐ No If yes, how many? _____

h. Employment Status: ■ Employee (no ownership) ☐ Sole Proprietor ☐ Partner ■% ownership
☐ S-Corporation Shareholder ■% ownership ☐ C-Corporation Shareholder ■% ownership

i. Do you plan to change your occupation, job or employment within the next six months? ☐ Yes ☐ No If yes, provide details:

j. Do you have any other part- or full-time occupations, jobs or employment? ☐ Yes ☐ No If yes, provide details:

4. Other Insurance Coverage of the Proposed Insured

a. Do you have disability insurance in force or applied for, or are you eligible for disability insurance within the next 12 months with any company, including Guardian or Berkshire? ☑ Yes ☐ No

b. Do you plan to apply for or are you currently applying for any other life, long-term care, disability or accident insurance? (In Remarks and Special Requests section 10, include amount applying for and company applying with, and whether this other insurance will be in addition to or in lieu of insurance with Berkshire or Guardian.) ■ Yes ■ No

c. Describe all disability income pending and in force coverage. If none, check here ☐

Type of Insurance: Individual (IDI), Group (G), Group with Conversion Option (GC), Overhead Expense (OE), Disability Buy-Out (DBO), Retirement Protection (RP), Association (A), Other (O – Explain)

Status: I = In Force, P = Pending, E = Eligible For

	Company Name	Type	Status	Benefit Amount	Benefit Period	Social Insurance Benefit	Catastrophic Benefit	Employer paid? (Y/N)	Is coverage being replaced? (Y/N)	Amount to be Replaced?	Date to be Replaced?
1.											
2.											
3.											
4											

5. Personal Financial Information of the Proposed Insured

For purposes of this section, Earned Income and Unearned Income mean the income you are required to report for federal income tax purposes. Earned Income includes W-2 wages, salary, tips, fees, bonuses, your share of the distribution of the owners actively involved in a business, net business income, and other sources of revenue. Unearned income includes passive income, income from dividends, capital gains, interest (including tax exempt interest), rentals, royalties, retirement plans, alimony, investments, and business interests as an inactive owner. Fill in the income amounts below using your individual and/or business tax returns and supporting schedules. "Actual filed" means the amount of income disclosed in your filed federal income tax return for the requested year. Explain in Section 10 Remarks and Special Requests, any significant fluctuations between years or changes since the end of the most recent calendar year. Show loss amounts in parentheses.

a. Earned Income 1. Year-To-Date This Calendar Year $_____ 2. Actual Filed Last Calendar Year $_____ 3. Actual Filed Two Calendar Years Ago $_____

b. Unearned Income 1. Actual Filed Last Calendar Year $_____ 2. Actual Filed Two Calendar Years Ago $_____
Sources: _____

c. Do you participate in a qualified retirement plan such as a 401(k), 403(b), SIMPLE, IRA or profit sharing? ☐ Yes ☐ No

d. Total Annual Retirement Contribution (including your contribution and employer contributions):
1. Year-To-Date This Calendar Year $_____ 2. Actual Last Calendar Year $_____ 3. Actual Two Calendar Years Ago $_____

e. Do you wish to have this retirement contribution considered as part of your earned income? ☐ Yes ☐ No

f. Total Net Worth if 6 million dollars or more (assets minus liabilities, excluding primary residence) $_____
Sources: _____

g. Have you ever filed bankruptcy? ☐ Yes ☐ No
If yes, Type: ☐ Personal ☐ Business Date Filed: _____ Date Discharged: _____

6. Additional Information of the Proposed Insured

(Please provide details in Section 10 Remarks and Special Requests to all "Yes" answers)

a. Do you plan to reside or travel outside of the U.S.? (If yes, indicate location, frequency, for work or pleasure, date of departure, length of stay.) ☐ Yes ☐ No

b. Do you drive a motor vehicle? _____ Driver's License State _____ Driver's License # ☐ Yes ☐ No

c. Within the past five years, have you been charged with or convicted of any motor vehicle moving violations or had your driver's license suspended or revoked? (If yes, details must include date of violation, description of violation and penalty.) ☐ Yes ☐ No

d. Within the last 10 years, have you been convicted of a felony, or is such a charge pending against you? ☐ Yes ☐ No

e. Indicate "yes" if any apply: 1) your professional license has ever been suspended or revoked; 2) there is a pending investigation or complaint concerning you with a regulatory, governmental, or other entity that oversees your profession; 3) you have ever been disbarred; or 4) you have ever been fined or sanctioned by an entity that oversees your profession. ☐ Yes ☐ No

f. Within the last three years, have you participated, or do you plan to participate in any of the following activities: piloting any type of aircraft; mountain or rock climbing; scuba diving; hang gliding; parachuting or skydiving; motor vehicle racing; or other hazardous activity? (If yes to any, complete Aviation and/or Avocation Supplement.) ☐ Yes ☐ No

g. Within the past five years, have you had any application for insurance declined, postponed, modified, rated, cancelled, rescinded, or have you withdrawn a pending application, or had a renewal or reinstatement request refused? ☐ Yes ☐ No

h. Have you used tobacco, nicotine, or any nicotine delivery system in any form in the last 12 months? (If you have quit, date last used: _____) ☐ Yes ☐ No

i. Are you currently a member of, or do you plan on joining, any branch of the United States Military, including the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard, or any reserve military unit? ☐ Yes ☐ No

j. Are you currently employed by, or seeking employment with, any company or entity which provides military, paramilitary, or security services outside of the United States? ☐ Yes ☐ No

k. Have you been alerted to, received orders for, or had any indication of an overseas assignment or active service with any branch of the United States Military, including the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard, or any reserve military unit? ☐ Yes ☐ No

7. Health Information of the Proposed Insured

■ This Section 7 is left intentionally blank. Information pertaining to my health and medical history will be provided by me in a separate Guardian or Berkshire form or forms which become part of my application. Additional questioning of your health and medical history may be required even when Section 7 is completed.

a. Name of your primary care physician: If none, check here ■ Address of primary care physician (Street, City, State, Zip): _____

b. Date and reason last consulted? _____

c. What treatment or medication was given or recommended? Primary care physician telephone: _____

d. Height _____ feet _____ inches Current Weight _____ lbs.

e. Weight change past year: ☐ None ☐ Gain*: ■ lbs. ☐ Loss*: ■ lbs. *Reason for change: _____

(Please provide details to all "Yes" answers in Section 10 Remarks and Special Requests. If any part of questions 7f through 7i is left blank or answered "Yes", no prepayment should be taken and no Conditional Receipt issued.)

f. Have you ever had or been treated for cancer, heart attack, stroke, diabetes, or any disease of the liver, lungs, kidneys, or heart, or any disorder of the back or spine or Chronic Fatigue Syndrome? ■ Yes ■ No

g. Are you currently receiving any medical advice, counseling or treatment for any medical, surgical or psychiatric condition? ■ Yes ■ No

h. Within the past 10 years, have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any deficiency of the immune system such as Human Immunodeficiency Virus? ☐ Yes ☐ No

i. Are you now pregnant? If yes, expected delivery date: ■ ☐ Yes ☐ No

j. Are you currently taking prescription medication, or have you been prescribed any medication within the last six months? ☐ Yes ☐ No

k. Have you ever had or been treated for cancer or tumor? ☐ Yes ☐ No

l. In the last 10 years, have you had, been treated for or received a consultation or counseling for:

1. high blood pressure, chest pain or disorder of the heart or circulatory system? ☐ Yes ☐ No
2. diabetes or disorder of the glands, bone, blood or skin? ☐ Yes ☐ No
3. arthritis, rheumatism, or disorder of the joints, limbs or muscles? ☐ Yes ☐ No
4. disorder or condition of the back, neck or spine? ☐ Yes ☐ No
5. disorder of the eyes, ears, nose or throat? ☐ Yes ☐ No
6. hernia, hepatitis, or disorder of the liver, gall bladder, esophagus, stomach, pancreas, spleen, intestines, colon or rectum? ☐ Yes ☐ No
7. epilepsy, stroke, dizziness, headache, muscle weakness, or disorder of the brain or spinal cord? ☐ Yes ☐ No
8. allergy, asthma, sinusitis, emphysema, disorder of the lungs or respiratory system, or sleep apnea? ☐ Yes ☐ No
9. complications of pregnancy, infertility, or any disorder of the breasts, reproductive or genital organs, prostate, kidneys, or urinary systems? ☐ Yes ☐ No
10. anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder? ☐ Yes ☐ No
11. Chronic Fatigue Syndrome, Fibromyalgia, Epstein Barr Virus or Lyme Disease? ☐ Yes ☐ No

m. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment or handicap? ☐ Yes ☐ No

n. Have you ever used stimulants, hallucinogens, narcotics or any other controlled substance, or been advised to have counseling or treatment for alcohol or drug use? (If yes, complete the Alcohol and Drug Usage Supplement.) ☐ Yes ☐ No

o. Within the past five years, have you had a sickness or injury for which you have made a benefits claim or for which you will make a benefits claim? ☐ Yes ☐ No

p. Within the past five years, have you had a physical exam or check-up of any kind? ☐ Yes ☐ No

q. Within the past five years, have you been advised to have surgery or any diagnostic tests that were not performed, except for HIV tests? ☐ Yes ☐ No

r. Other than previously stated on this application, in the last five years have you received medical advice or counseling from physician(s), medical or mental health professional(s), counselor(s), psychotherapist(s), chiropractor(s), or other practitioner(s), or have you been a patient in a hospital, clinic, sanatorium, or other medical facility? ☐ Yes ☐ No

s. Within the past 12 months, have you had symptoms of any condition listed in this Section 7, except those conditions listed in question 7h, for which you have not sought medical attention or advice? ☐ Yes ☐ No

t. Do either of your parents have a history of: diabetes; cancer; high blood pressure; heart disease; Huntington's Disease or mental illness? ☐ Yes ☐ No

	Age if Living	Age at Death	Cause of Death
FATHER			
MOTHER			

Catastrophic Disability Benefit Rider – Complete the following questions if applying for this rider:

(If any part of questions 7u through 7x is answered "Yes," no prepayment should be taken and no Conditional Receipt issued.)

u. Have you ever had an injury or sickness that caused a loss of: sight in both eyes; hearing in both ears; speech; or the use of two arms or two legs? ☐ Yes ☐ No

v. Do you need human assistance of any kind to perform everyday activities such as bathing, continence, dressing, eating, using the toilet or transferring (for example, from the chair to your bed)? ☐ Yes ☐ No

w. Do you use any special medical equipment or appliances, including but not limited to, a wheelchair, pacemaker, oxygen tank, cane, catheter, or artificial limb? ☐ Yes ☐ No

x. Have you ever received treatment, attention or advice for memory loss or confusion, Alzheimer's disease, stroke, senility, dementia, loss of speech or comprehension of spoken language? ☐ Yes ☐ No

8. Premium Information

a. What percentage of the premium for the coverage you are applying for will be paid by your employer? ☐ None ☐ 100% ■ Other _____%

b. If your employer will pay any part of the premium, will it be reportable by you as taxable income? ☐ Yes ☐ No

c. If paid by the proposed insured, is it paid by: ☐ Pre-tax dollars ☐ After-tax dollars

d. Premium Mode: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly – *available with Group Bill and Automatic Bank Draft only*

e. Billing Type: ☐ Paper Bill
☐ Automatic Bank Draft: ☐ New service ☐ Add to my existing Guardian or Berkshire service
■ Group Bill: ☐ Existing Account # _____
☐ New – Billing Name _____ Common Billing Day _____

f. Send premium notices to: ☐ Residence ☐ Owner's Address ☐ Business ☐ Other _____

g. Prepayment of Premium – *A prepayment must be accompanied by a signed Conditional Receipt and section 7 must be completed.*
☐ No money has been submitted with this application.
☐ $_____ has been submitted with this application for proposed insurance.

9. Coverage Applied For

Indicate all insurance applied for with this application and specify coverage desired. Complete column A and question g when applying for ProVider Plus, column B and question h for Retirement Protection as a stand-alone policy, and column C and questions i through m for Reducing Term. Complete the appropriate product supplement for Overhead Expense and Disability Buy-Out.

	Column A	Column B	Column C	Column D	Column E
	Disability Income	Disability Income – Retirement Protection	Reducing Term	Overhead Expense	Disability Buy-Out
a. Indemnity/Benefit Amount	$	$	$	$	Complete Supplement
b. Policy Form Number					
c. Premium Structure	■ Level ■ Graded	■ Level ■ Graded	Level	Level	Level
d. Elimination Period					
e. Benefit Period/Term		To Age 65			
f. Occupation Class					
Supplemental Benefits	Complete question g	Complete question h	Complete questions i-m	Complete Supplement	Complete Supplement

Complete the Following When Applying for Disability Income (including Retirement Protection)

g. Supplemental Benefits – ProVider Plus
☐ Residual Disability ☐ Partial Disability
■ Cost of Living Adjustment:
☐ 3% Compound ☐ 6% Maximum ☐ Four-Year Delayed
☐ Graded Lifetime Indemnity for Total Disability
■ Lump Sum Disability Benefit
☐ Unemployment Waiver of Premium
☐ Future Increase Option $_____
☐ Catastrophic Disability Benefit $_____
☐ Social Insurance Substitute $_____
☐ Retirement Protection Plus:
Monthly Indemnity $_____
Elimination Period ☐ 180 days ☐ 360 days
☐ Other _____

h. Supplemental Benefits – ProVider Plus: Retirement Protection
■ Cost of Living Adjustment:
☐ 3% Compound ☐ 6% Maximum
☐ Future Increase Option
$_____
☐ Other _____

Complete the Following When Applying for Reducing Term Insurance

i. Loss Payee Name:

(Must be the individual or entity that the money is owed to.)

Loss Payee Tax ID #: _____ - _____

Business Address (Street, City, State, Zip):

Owner Name: _____

Owner Tax ID #: _____ - _____

j. Provide type and reason that the obligation was incurred:

- ☐ Business Loan
- ☐ Purchase Agreement
- ☐ Employment Contract
- ☐ Student Loan – Have you deferred payments of this loan or do you intend to do so?
  ☐ Yes ☐ No If yes, describe how long below.
  Details:
- ☐ Other _____

k. Date obligation took effect (mm/dd/yyyy):

l. Names of all debtors or guarantors:

_____

_____

_____

m. Periodic payment in the amount of $_____ is to be made each month for _____ months

Periodic payment in the amount of $_____ is to be made each month for _____ months

Periodic payment in the amount of $_____ is to be made each month for _____ months

I am responsible for payments for a total of _____ months

10. Remarks and Special Requests

Provide all details to any "yes" answers, identifying each detail by question number. Include, if applicable, diagnosis or symptoms, tests performed, dates, types and amounts of medication, length of disability, degree of recovery, and names and addresses of all physicians, medical or mental health professionals, counselors, psychotherapists, chiropractors, practitioners or hospitals. Also include in this section any special policy requests such as specific policy date other than as provided by the terms of this application. For additional space use the Supplement to the Application for Insurance (C-APP-SUPP).

11. Amendments or Corrections (For Home Office Use Only)

12. Representations of the Proposed Insured and Owner

Those parties who sign below, agree that:

1. This Application for Disability Insurance, any required Representations to the Medical Examiner, and any other supplements or amendments to this Application for Insurance will form the basis for, and become part of and attached to any policy or coverage issued and is herein referred to as the "Application."
2. All of the statements that are part of this Application are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them.
3. No agent, broker or medical examiner has any right to accept risks, make or change contracts, or to waive or modify any of the Company's rights or requirements.
4. Any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk, claims payment, or may lead to rescission of any policy that is issued based on this Application.
5. All coverage shown to be replaced in answer to Question 4c of this application will be permanently terminated on or before the date(s) indicated. If not, it is understood and agreed that the Company reserves all rights outlined in any policy issued and those available by law. Further, benefits under any policy or coverage issued based on this application may be reduced by the amount payable under such existing policies.
6. The policy date is the date from which premiums are calculated and become due. Except as provided in the Conditional Receipt (if an advance payment has been made and acknowledged and such Receipt issued), no insurance shall take effect unless and until the policy is delivered, the first premium is paid, and there has been no change in the health, the income level, status of employment or occupation of the proposed insured. If disability insurance becomes effective in the manner stated in the Conditional Receipt, the amount of such insurance shall not exceed the limits set forth in such Receipt. If a request is made for coverage to commence as of a specified date, it is understood and agreed that certain rights under the conditional receipt may be waived.
7. Changes or corrections made by the Company and noted in the "Amendments or Corrections" section are ratified by the owner upon acceptance of a policy containing this Application with the noted changes or corrections. In those states where written consent is required by statute or State Insurance Department regulation for amendments as to plan, amount, classification, age at issue, or benefits, such changes will be made only with the owner's written consent.
8. By paying premiums on a basis more frequently than annually, the total premium payable during one year's time will be greater than if the premium were paid annually. That is, the cost of paying annualized periodic premiums will be more than the cost of paying one annual premium.
9. If applying for Disability Buy-Out insurance, if no written buy-sell agreement is in place, one must be executed before a disability occurs that would qualify for benefits under the policy. Otherwise, the Company will have no liability other than to refund premiums. We will require a written assurance within one year of the policy date that an agreement is in place. If no assurance is received, the policy will be voided and the premiums refunded.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties.

Signed at _____ this _____ day of _____, _____.
City and State Day Month Year

_____ _____
Signature of Proposed Insured Signature of Applicant/Owner if Other than Proposed Insured

_____
Witness

Berkshire Life Insurance Company of America
Home Office: 700 South Street, Pittsfield, MA 01201
Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of
The Guardian Life Insurance Company of America, New York, NY

Application for Disability Insurance –
Income ProVider Disability Insurance Supplement

I. Proposed Insured Information

a. Name (First, Middle Initial, Last)

b. Date of Birth (mm/dd/yyyy)

2. Personal Disability Insurance

a. Case # _____

b. Supplemental Benefits

- ☐ Basic Residual Disability
- ☐ Enhanced Residual Disability
- ☐ Extended Own Occupation
- ☐ True Own Occupation
- ☐ Cost of Living Adjustment
  - ☐ 3% ☐ 6%
- ☐ Catastrophic Disability Benefit $_____
- ☐ Other _____

Berkshire Life Insurance Company of America
Home Office: 700 South Street, Pittsfield, MA 01201
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The Guardian Life Insurance Company of America, New York, NY

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Application for Disability Insurance –
Disability Buy-Out Insurance Supplement

1. Proposed Insured Information

a. Name (First, Middle Initial, Last)

b. Date of Birth (mm/dd/yyyy)

2. Disability Buy-Out Insurance

a. Funding: ☐ Monthly ☐ Lump Sum ☐ Down Payment Benefit Amount: Monthly: $_____ Lump Sum: $_____

b. Supplemental Benefits: ☐ Future Increase Option: Monthly: $_____ Lump Sum: $_____
☐ Other

c. Type of disability buy-sell agreement: ☐ Cross Purchase ☐ Entity Purchase ☐ Trusteed Cross Purchase
Status of disability buy-sell agreement: ☐ In force and dated _____ ☐ Date to be executed _____

d. Owner Information

Name of Owner (First, Middle Initial, Last) or name of trust or company: _____

Relationship to the Proposed Insured _____

Social Security #: ___ - ___ - ___

Tax ID #:

Address (Street, City, State, Zip):

_____

_____

Please complete the following if owner is a trust:

Date of Trust (mm/dd/yyyy): _____

Complete Names of Trustees:

_____

_____

e. Give names of all other stockholders or partners. If more than four partners or if there are any on whom Disability Buy-Out is not carried or proposed on the Supplement to Application for Insurance, list or explain in the Application for Disability Insurance, Section 10 Remarks and Special Requests.

Name and Title	Percentage Owned	Amount of DBO in Force	Amount of DBO Proposed
	%	$	$
	%	$	$
	%	$	$
	%	$	$

f. Does a familial relationship exist among any of the above stockholders or partners? ☐ Yes ☐ No
If yes, describe in the Application for Disability Insurance, Section 10 Remarks and Special Requests.

g. Indicate type of business organization: ☐ Professional Corporation/Personal Service Partnership
☐ Commercial Business

h. Business Financial Information

		Column A	Column B	Column C
1. Total Assets	$	Year-To-Date This Calendar Year	Actual Filed Last Calendar Year	Actual Filed Two Calendar Years Ago
2. Total Liabilities	$			
3. Business Net Worth *(line 1 minus line 2)*	$			
4. Gross Annual Sales		$	$	$
5. Net Profit After Taxes		$	$	$

Berkshire Life Insurance Company of America
Home Office: 700 South Street, Pittsfield, MA 01201
Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of
The Guardian Life Insurance Company of America, New York, NY

Application for Disability Insurance –
Overhead Expense Insurance Supplement

I. Proposed Insured Information

a. Name (First, Middle Initial, Last)

b. Date of Birth (mm/dd/yyyy)

2. Overhead Expense Insurance

a. Supplemental Benefits ☐ Future Increase Option $_____
☐ Supplemental Overhead Expense Benefit ☐ Other _____

b. Your share of covered expenses? $_____ and _____% of total.

c. Are there other employees in the firm who generate revenue? ☐ Yes* ☐ No

*If yes, what is the compensation for these employees, their title(s) and the percentage of gross revenue they generate? Provide details in the Application for Disability Insurance, Section 10 Remarks and Special Requests.

d. Owner Information (if other than the Proposed Insured)

Name of Owner (First, Middle Initial, Last) or name of trust or company: _____

Relationship to the Proposed Insured:

Owner's Address (Street, City, State, Zip):

Tax ID or Social Security #: _____

e. Monthly Expenses of the Business Entity – What are the current average monthly overhead expenses incurred for the items shown? (If responsible for expenses shared jointly with others, include only the portion for which the proposed insured is responsible.)

Advertising	$_____
Car and Truck Expenses	_____
Commissions and Fees	_____
Contract Labor	_____
Depreciation and Section 179 Expense Deduction	_____
Employee Benefit Programs	_____
Insurance	_____
Mortgage Interest (Paid to Banks, etc.)	_____
Other Interest	_____
Legal and Professional Services	_____
Office Expenses	_____
Pension and Profit Sharing Plans	_____
Rent or Lease (Other Business Property)	_____
Repairs and Maintenance	_____
Taxes and Licenses	_____
Utilities	_____
Wages (exclude compensation for members of insured's profession)	_____
Other Expenses (itemized):	
_____	_____
_____	_____
TOTAL (Should agree with 2b.)	$_____
Proposed Insured Monthly Earned Income*	$_____

*Earned income is considered for and in accordance with Salary Replacement guidelines of 50% of the Proposed Insured's Earned Income not to exceed one-half of the total monthly overhead expense benefit or $10,000, whichever is less. Available with policy form 4200 Salary Replacement.

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☐ **The Guardian Life Insurance Company of America**
Administrative Office: 700 South Street, Pittsfield, MA 01201

(Please check appropriate company(ies). Any insurer checked above is herein referred to as the "Company.")

Representations of Health Information | Non-Medical

Name (First, Middle Initial, Last) Date of Birth (mm/dd/yyyy)

a. Name of your primary care physician: If none, check here ☐ Address of primary care physician (Street, City, State, Zip):

b. Date and reason last consulted?

c. What treatment or medication was given or recommended?

Primary care physician telephone: _____

d. Height _____ feet _____ inches Current Weight _____ lbs.

e. Weight change past year: ☐ None ☐ Gain*: _____ lbs. ☐ Loss*: _____ lbs. *Reason for change: _____

(Please provide details to all "Yes" answers in the Remarks section below.)

f. Have you ever had or been treated for cancer, heart attack, stroke, diabetes, or any disease of the liver, lungs, kidneys, or heart, or any disorder of the back or spine or Chronic Fatigue Syndrome?	☐ Yes ☐ No
g. Are you currently receiving any medical advice, counseling or treatment for any medical, surgical or psychiatric condition?	☐ Yes ☐ No
h. Within the past 10 years, have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any deficiency of the immune system such as Human Immunodeficiency Virus?	☐ Yes ☐ No
i. Are you now pregnant? If yes, expected delivery date:	☐ Yes ☐ No
j. Are you currently taking prescription medication, or have you been prescribed any medication within the last six months?	☐ Yes ☐ No
k. Have you ever had or been treated for cancer or tumor?	☐ Yes ☐ No
l. In the last 10 years, have you had, been treated for or received a consultation or counseling for:	
1. high blood pressure, chest pain or disorder of the heart or circulatory system?	☐ Yes ☐ No
2. diabetes or disorder of the glands, bone, blood or skin?	☐ Yes ☐ No
3. arthritis, rheumatism, or disorder of the joints, limbs or muscles?	☐ Yes ☐ No
4. disorder or condition of the back, neck or spine?	☐ Yes ☐ No
5. disorder of the eyes, ears, nose or throat?	☐ Yes ☐ No
6. hernia, hepatitis, or disorder of the liver, gall bladder, esophagus, stomach, pancreas, spleen, intestines, colon or rectum?	☐ Yes ☐ No
7. epilepsy, stroke, dizziness, headache, muscle weakness, or disorder of the brain or spinal cord?	☐ Yes ☐ No
8. allergy, asthma, sinusitis, emphysema, disorder of the lungs or respiratory system, or sleep apnea?	☐ Yes ☐ No
9. complications of pregnancy, infertility, or any disorder of the breasts, reproductive or genital organs, prostate, kidneys, or urinary systems?	☐ Yes ☐ No
10. anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder?	☐ Yes ☐ No
11. Chronic Fatigue Syndrome, Fibromyalgia, Epstein Barr Virus or Lyme Disease?	☐ Yes ☐ No

m. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment or handicap?	☐ Yes ☐ No
n. Have you ever used stimulants, hallucinogens, narcotics or any other controlled substance, or been advised to have counseling or treatment for alcohol or drug use? (If yes, complete the Alcohol and Drug Usage Supplement.)	☐ Yes ☐ No
o. Within the past five years, have you had a sickness or injury for which you have made a benefits claim or for which you will make a benefits claim?	☐ Yes ☐ No
p. Within the past five years, have you had a physical exam or check-up of any kind?	☐ Yes ☐ No
q. Within the past five years, have you been advised to have surgery or any diagnostic tests that were not performed, except for HIV tests?	☐ Yes ☐ No
r. Other than previously stated on this application, in the last five years have you received medical advice or counseling from physicians, medical or mental health professionals, counselors, psychotherapists, chiropractors, or other practitioners, or have you been a patient in a hospital, clinic, sanatorium, or other medical facility?	☐ Yes ☐ No
s. Within the past 12 months, have you had symptoms of any condition listed in this Section 7, except those conditions listed in question 7h, for which you have not sought medical attention or advice?	☐ Yes ☐ No
t. Do either of your parents have a history of: diabetes; cancer; high blood pressure; heart disease; Huntington's Disease or mental illness?	☐ Yes ☐ No

	Age if Living	Age at Death	Cause of Death
FATHER			
MOTHER			

Remarks

Provide all details to any "yes" answers, identifying each detail by question number. Include, if applicable, diagnosis or symptoms, tests performed, dates, types and amounts of medication, length of disability, degree of recovery, and names and addresses of all physicians, medical or mental health professionals, counselors, psychotherapists, chiropractors, practitioners or hospitals. For additional space use the Supplement to the Application for Insurance (C-APP-SUPP).

I understand and agree that the statements and answers in this Representations of Health Information (Non-Medical) are written as made by me; to the best of my knowledge and belief are full, complete and true; and that they shall be a part of the contract of insurance, if issued.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties.

Signed at _____ this _____ day of _____, _____.
City and State Day Month Year

_____ _____
Witness Signature of Proposed Insured

SERFF Tracking Number:	*GARD-126966349*	*State:*	*Arkansas*
Filing Company:	*The Guardian Life Insurance Company of America*	*State Tracking Number:*	*47678*
Company Tracking Number:	*DI-2011*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.007 Long Term - Related to marketing with employer or association groups*
Product Name:	*DI-2011*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	01/12/2011

Comments:

Attachment:

Guardian Application Flesch Score.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	01/12/2011

Comments:

submitted on Form Schedule for approval

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	01/12/2011
Bypass Reason:	n/a - Application form filing		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	01/12/2011
Bypass Reason:	n/a - application form filing		

Comments:

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
700 South Street
Pittsfield MA 01201

CERTIFICATION

This is to certify that the forms listed below comply with the readability ease standards of the Life and Health Policy Simplification Act, Section 5a.

Form Number	Sentences	Words	Syllables	Flesch Score
DI-2011	165	4732	7626	50.6
DI-NM-2009	73	1825	2,760	53.5

January 3, 2011

John J. Monahan, Officer
Director of Individual Market Compliance